

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2010
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/12/2010
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FEB 26 2010
Director's Office

NAME OF PROVIDER OR SUPPLIER MILLCROFT	STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from January 4, 2010 through January 12, 2010. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 93. The survey sample included forty (40) census sample residents and thirty (30) admission sample residents in Stage 1. The Stage II sample totaled forty-seven (47) residents. Additionally, there were two subsampled residents (SSR1 and SSR2) who were not part of the Stage II sample.	F 000		
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Millicroft agrees with the allegations and citations listed on the statement of deficiencies. Millicroft maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall serve as Millicroft's written credible allegation of compliance as of the last POC completion date. By submitting this plan of correction, Millicroft does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Millicroft reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding. F 156 1. Resident R88 is no longer in the building, no corrective action can be taken.	2/25/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER

MILLCROFT

STREET ADDRESS, CITY, STATE, ZIP CODE
255 POSSUM PARK ROAD
NEWARK, DE 19711

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F 156	<p>Continued From page 1</p> <p>and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification</p>	F 156	<p>2. The Social Service Director will review all recent Medicare discharges to determine if there are any other residents who should have received a Notice of Medicare Provider Non-coverage. Corrective action will be taken.</p> <p>3. The Social Service Director will have a binder in place for all Medicare residents and place a Non-coverage Notice upon admission. The Notice will be completed prior to discharge and given to the resident and/or responsible party. The NHA will conduct randomly weekly audits for the next 60 days to assure appropriate notice has been given. Corrective action will be taken immediately.</p> <p>4. The results of the audits will be shared with the QA Committee for the next 60 days as a means of assuring ongoing compliance.</p>	

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F 156	<p>Continued From page 2</p> <p>agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's liability notices, it was determined that the facility failed to provide notice of termination of benefits for one (R88) out of three residents reviewed. Findings include:</p>	F 156			

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F 156	Continued From page 3 There was no Notice of Medicare Provider Non-coverage letter (Medicare cut letter) provided for R88. Therefore the resident was not notified when and why the coverage was discontinued.	F 156		
F 225 SS=D	Interviews on 1/5/10, 1/6/10 and 1/12/10 with E7 (social service director), who is responsible for the Medicare cut letters, confirmed this finding. 483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	F 225 1. Resident R89 remains in the facility and the care plan was revised in 1/09 to reflect that R89 will not have any male aides to provide care. 2. All residents have the potential to be affected by this cited practice. 3. An educational in-service will be provided to all currently employed management staff on the facility's abuse, incident investigation, and reporting procedures. All grievances will be presented and reviewed in the Daily stand up meeting to assure appropriate resolutions have been achieved.	3/6/10

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F 225	<p>Continued From page 4</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to ensure that an allegation of physical abuse was immediately reported and investigated for one (R89) out of 47 sampled Stage II residents. Findings include:</p> <p>R89 was admitted to the facility on 8/17/09 with diagnoses including left hip pain with difficulty walking, osteoporosis, stroke, diabetes and dementia. The quarterly Minimum Data Set Assessment (MDS), dated 11/14/09, coded R89 as having a short term memory problem, the long term memory was OK, and cognitive skills for daily decision making was coded as modified independence.</p> <p>On 1/5/10, during an interview, R89 stated that he felt that once he was treated roughly by staff. On 1/8/10, during an interview with E3 (Assistant Director of Nursing - ADON), E3 stated that no incident report was done when R89 complained of rough treatment. E3 stated that it was during the time that R89 had a urinary tract infection (UTI) and was delusional. E3 stated that he referred the rough treatment, allegation of abuse to E7 (Social Worker) who followed it up as a grievance. The grievance report was dated 10/13/09 and the summary stated, "Resident told the social worker from another facility who was</p>	F 225	<p>4. All incident/grievance reports that require investigations will</p> <p>Be reviewed by the NHA for thorough completion to</p> <p>Assure compliance to facility policy and state reporting</p> <p>Guidelines as they occur. Problems related to incidents,</p> <p>Investigations and reporting will be discussed in the daily</p> <p>Stand up for further remedial action and will be reviewed by the QA Committee for the next 60 days as a means of assuring ongoing compliance.</p>		

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F 225	Continued From page 5 visiting - that three males came in to his room yesterday and were doing inappropriate things to him - being rough, etc." Review of the nurse's notes, dated 10/5/09, revealed that R89 started on antibiotic therapy for a UTI for 7 days. A nurse's note, dated 10/12/09, the day of the alleged abuse, stated that R89 was "AXOX3" (alert and oriented to person, place and time). The facility failed to report to the state agency an allegation of abuse which was made by R89 regarding rough treatment. Consequently the facility failed to conduct a thorough investigation. On 1/11/10, E2 (Director of Nursing) acknowledged these findings, confirming that the facility should have completed an incident report. 483.15(a) DIGNITY	F 225			
F 241 SS=E	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to ensure that 15 out of 47 Stage II residents (R235, F161, R234, R145, R55, R131, R34, R2, R87, R54, R28, R4, R64, R82, R137) were treated in a dignified manner. Findings include: During the evening meal on Saturday, 1/9/10 at 5:40 PM in the restorative first floor dining room, four residents, (F235, F161, F234 and R145) were observed seated at tables waiting for their	F 241	F 241 1. R235, R161, R131, R2, R34, R137 are no longer in the facility. R234, R145, R55, R87, R54, R28, R4, R64, R82, remain in the facility. There were no negative outcome to the Residents that did not receive their meals at the same time of the other residents. There were no negative outcomes for those residents not fed properly or accommodated timely and appropriately during the dining experience. R4 Plan of Care was revised to assure she is provided fresh cold water at regular intervals during the day.		3/6/11

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F 241	<p>Continued From page 6</p> <p>meals while other residents at their tables were already served.</p> <p>1. R235 was observed seated at a table with a visitor waiting for his meal to be served while another resident at his table ate his dinner. When his meal was eventually served the visitor stated that R235 waited almost half an hour for his meal after the other resident was served.</p> <p>2. R234 was observed seated at a table with a visitor waiting for her meal to be served while another resident at her table ate her dinner. When her meal was eventually served, the visitor stated that R234 waited at least 20 minutes for her meal after the other resident was served.</p> <p>3. R145 was observed seated at a table with two other residents (R161 and R82) waiting for her meal. R82 had already been served but was not eating her dinner. R145 was served her meal 15 minutes later.</p> <p>4. R161 was observed seated at a table with two other residents (R145 and R82) waiting for her meal while R82 had already been served but was not eating her dinner. R161 was served her meal 15 minutes later.</p> <p>5. During the dinner dining observation on 1/9/10 at 6:20 PM, E16 (CNA) stood when she fed R55.</p> <p>6. During the dinner dining observation on 1/9/10 at 6:20 PM, E16 stood when she fed R131.</p> <p>7. During the dinner dining observation on 1/9/10 at 6:20 PM, E16 stood when she fed R34.</p> <p>R55 and R131 sat opposite each other. Also,</p>	F 241	<p>E15, E17, E16, E9 will be counseled and in-serviced on proper servicing of meals and feeding of residents during meal time. They will be also be provided educational in-servicing on maintaining infection control practices during dining.</p> <p>2. All residents have the potential to be affected by these cited practices.</p> <p>3. The Nursing Supervisor or their designee will make rounds during meal times to assure that any resident identified to need assist with meal set up or feeding will be served and accommodated timely.</p> <p>An in-service training will be provided to all current license and Direct care staff on proper dining and serving techniques.</p> <p>4. A random audit of the serving of meals will be</p>		

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F 241	<p>Continued From page 7</p> <p>seated at the same table were R34 and E67. E16 continued to go back and forth between R55 and R131 around R34. E16 then fed R34. There was an empty chair situated diagonally at the opposite corner of the table which the CNA could have used while feeding residents. E16 stood the entire time when she fed these residents.</p> <p>8. During the dinner dining observation on 1/9/10, E17 (CNA) came over to R2, who appeared lethargic and sleepy, and tried to awaken this resident in order to feed her. She was having difficulty getting R2 to respond, at which time, E15 (nurse) came over to the table to assist. After E17 left to help other residents, E15 was observed standing to feed R2. Soon afterwards, E17 returned and also stood when she fed this resident.</p> <p>9a. During the dinner dining observation on 1/9/10, E16 served coffee to R87. A few minutes later, E16 removed the cloth tablecloth from R87's table while he drank his coffee and watched the ball game on TV.</p> <p>9b. During the dinner dining observation on 1/9/10, R37 dropped her cup of ice on her lap, which then landed on the floor. E15 used R37's blue cloth napkin to try to wipe up some of the spill, then left the napkin on the floor so no one else would accidentally step there. However, a short time afterwards, E16, started to remove empty dishes from the table and picked up the soiled napkin used to mop the floor and placed it back up on the table, while R87 continued to eat.</p> <p>10. During the dinner dining observation on 1/9/10, E16 served coffee to R54. Again, E16 prematurely removed R54's tablecloth before he</p>	F 241	<p>conducted weekly By the DON /Designee with emphasis on the dinner meal and weekends for one month. A Random Audits will then be conducted monthly x2 months then quarterly to ensure sustained compliance. Findings will reported in QA meeting with corrective actions as warranted.</p>		

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F 241	Continued From page 8 was finished drinking his coffee and watched the ball game on TV.	F 241			
	<p>E16 continued to clear other tables, sweep the floor and eventually went back to feeding R131 while standing. Finally at about 7 PM, all residents had finished eating and were returned either to their rooms or placed in the hallway around the nursing station.</p> <p>During an interview on 1/9/09 at 7:40 PM with E15, she acknowledged that staff should not stand while feeding residents or remove tablecloths before residents finished their meals and agreed that it was a dignity issue. E15 agreed that the soiled napkin should never have been placed back on a table after it had been on the floor. She also acknowledged failing to offer R87 an alternate.</p> <p>11. On 1/4/2010 at 12:38 PM during lunch time, R28 was observed seated at a table, drinking from a plastic glass. R28 was heard telling E9 (nurse) that she was not done eating when asked whether she was done with her meal. Less than five minutes later, R28 again responded "No" to E9 when asked if she was done with her meal. Although the resident had completed her entree, she was still drinking her beverage at the table. Despite the resident having told E9 twice that she was not done, E9 unlocked R28's wheelchair and placed her at the side of the table at which time R28's beverage fell to the floor.</p> <p>E9 was then observed folding linens at the table where R28 had been removed, proceeded to get a sign for the wet floor and then was observed moving R28 in her wheelchair out of the dining room.</p>				

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F 241	<p>Continued From page 9</p> <p>12. The facility's policy titled, Hydration Management, stated, "Fresh water and ice will be maintained at the bedside unless contraindicated..."</p> <p>Review of R4's quarterly Minimum Data Set (MDS) assessment, dated 11/2/09, revealed that she had no short or long term memory problems.</p> <p>a. During the stage 1 interview with R4 on 1/5/10, she stated that staff did not provide her with fresh water on a regular basis. In subsequent interviews with R4 on 1/8/10 at 9:45 AM and 1/11/10 at 11:00 AM, she stated that the cup of water that she had on her table was provided early in the morning at about 6:00 AM. Observation of her water cup on 1/11/10 revealed that it was no longer cold. R4 stated that she preferred cold water.</p> <p>b. During an interview with R4 on 1/8/10, she stated that the night before she had to go to the bathroom. She stated that the Certified Nurse Aid (CNA) told her to wait. He came back in 15 minutes and she had wet herself.</p> <p>13. Review of R64's quarterly MDS assessment, dated 12/10/09, revealed that she had no short or long term memory problems.</p> <p>R64 shared a room with R4. During interviews with R4, R64 agreed that staff did not bring water to them on a regular basis. Observation of R64's water cup on 1/11/10 at 11:00 AM, revealed that it was almost empty. R64 stated that she had some vomiting in the morning and needed some more water.</p>	F 241		

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F 241	<p>Continued From page 10</p> <p>14. During observations on Saturday evening, 1/9/10, R137's call bell was turned on at 7:25 PM and then turned off at 7:33 PM. At 7:35 PM the resident was observed sitting in her room alone. When asked if staff came to assist her when she rang the call bell, she stated that someone came in and told her that they would be right back to take her to the bathroom. Staff was observed entering R137's room at 7:50 PM, 25 minutes after the resident called, to assist her to the bathroom.</p> <p>15. Throughout the survey from 1/4/10 through 1/12/10, R82 was observed eating lunch in the restorative dining room with staff assisting her and offering encouragement.</p> <p>R82's Nutritional Assessment, dated 11/3/09, stated that, "Resident able to feed self but need (sic) cueing." Her "Alteration in Nutrition" care plan, last updated on 11/3/09, identified the problem: "Decreased PO (oral) intake Secondary to: Poor appetite..." Approaches included, "Assist with meals as needed" and "Encourage meal completion."</p> <p>In an interview with E30 (CNA) on 1/12/10, she stated that R82 needed lots of encouragement to eat.</p> <p>During meal observations on Saturday, 1/9/10 at 5:40 PM, one staff person was observed in the restorative dining room on the first floor where approximately 12 residents were eating. R82 was observed seated at a table asleep with two other residents with her meal in front of her uncovered. Fifteen minutes later a staff person came over to her table to assist and encourage her to eat.</p>	F 241			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2010
NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE	
F 248 SS=D	<p>483.15(f)(1) ACTIVITIES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, it was determined that the facility failed to provide an ongoing program of activities to meet the needs of two (R223 and R98) out of 47 Stage II sampled residents. Findings include:</p> <p>R223 was admitted to the facility on 12/11/09 from the hospital with diagnoses of liver disease, depression, anemia and c-diff.</p> <p>On 1/5/10 at 9:15 AM and 2:30 PM, R223 was observed in her room in bed.</p> <p>According to R223's MDS (Minimum Data Set) Assessment, dated 12/18/09, the resident's average time involved in activities was coded as a "1" or participating in activities from 1/3 to 2/3 of the time. The MDS stated that her preferred activity settings were in her room and she enjoyed playing cards, exercise/sports, music, reading/writing, spiritual/religious activities, trips/shopping, walking, watching TV, gardening or plants, talking or conversing, and helping others.</p> <p>R223's Activity Assessment, dated 12/16/09, stated she was "independent with activity of choice.....independent with decisions and choices.....provide support room visits and</p>	F 248	<p>F 248</p> <ol style="list-style-type: none"> Corrective action was implemented for resident R223 with new guidelines in place to assure proper 1:1 visit documentation and resident refusal of activities. Care Plan for resident R 98 was updated on 1/14/2010 and reviewed to reflect resident needs. Initial care plans and goals will be reviewed to assure the deficient practice is not applicable to other residents. Immediate corrective action will be taken. Monthly audits of charts and documentation will be completed by the Recreation Director. The Recreation Director will review care plans of hospice and comfort care residents weekly to assure care plan accuracy for group activity participation is updated and accurate. 	3/31/11	

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NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
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F 248	<p>Continued From page 12</p> <p>conversation in attempt to increase social/stim (stimulation) support"....The individualized care plan goals in the activity assessment stated: "provide multiple invitations, reminders and escorts prior to activity start times.....encourage participation to group activities...after all attempts to engage in group programming respect decision to refuse"...."one-to one visits, in room projects, self directed activities".</p> <p>Review of R223's care plan initiated on 12/16/09 and last reviewed on 1/4/10 for independent leisure/interest pursuits revealed goals to include, "R223 will actively participate and independently pursue her leisure interests within a large group, small group or self-directed setting of choice". R223's approaches in the plan included "...encourage participation in group activities", "highlight areas of interest such as dining out, cards, gardening, baseball, golf, puzzles, word games, ...cooking,conversation, TV", "provide multiple invitations, reminders and escorts prior to activity start times", "after all attempts to engage in group programming respect decision to refuse", "provide spontaneous room visits and conversation in an attempt to increase social/stim opportunities".</p> <p>Recreation progress notes, dated 12/16/09, indicated that R223 was independent with her activities and enjoyed conversations with family. It also indicated that the resident would be encouraged to participate in out of room activities but would respect the resident's right to refuse. Progress notes dated 1/4/10 revealed that the resident did not attend organized activities and stated the facility would encourage out of room activities and conduct daily 1-1 visits.</p> <p>Review of R223's Daily Activity Program</p>	F 248	<p>Corrective action will be taken. In-service training on proper documentation for Recreation Assistants is scheduled for 2/3/2010.</p> <p>4. The results of the audits will be presented to the QA Committee for the next 60 days to assure ongoing compliance.</p>		

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NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
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F 248	<p>Continued From page 13</p> <p>Participation Log from December 16, 2009 through January 5, 2010 lacked documented evidence that R223 was invited to and/or refused activities. Review of Participation Log Sheets for group activities revealed that she had attended two group activities, one in 12/30/09 and one on 1/2/10. Review of nurses notes, recreation progress notes, and activity logs for one-to one lacked evidence the staff had encouraged participation or noted refusals.</p> <p>On 1/8/10 at 8:00 AM , an interview with the E10 (Recreational Aide) revealed that she takes the daily activity schedule to resident's rooms. E10 stated that they encourage and get residents from their rooms that always come to activities to participate in the activities of the day. She stated she does not go to see all residents in the facility to let them know of activities and the times of the activities.</p> <p>On 1/8/10 at 12:36 PM , an interview with the E8 (Recreation Director) revealed that R223 liked to stay in her room and that she required one-to-one visits. E8 stated that R223 came to activities with her husband a few times. She stated that R223's husband came to visit her and would stay with her all day. E8 stated that the Activity staff would take the Daily Calendar to R223's room and encouraged her to participate in the group activities. She stated her staff usually encouraged residents to participate prior to the activities but were not documenting the information on the activity logs. E8 confirmed that they did not document the activity refusals by residents.</p> <p>There was no evidence that the facility followed R223's activity care plan and no documentation that the resident was offered or encouraged to.</p>	F 248			

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F 248	<p>Continued From page 14</p> <p>participate in activities for other than two days.</p> <p>2. R98 was admitted to the facility on 5/27/06 with diagnoses that included Alzheimer Disease. On 1/3/10, R98 was readmitted to the facility, post fall on 1/1/10, which resulted in a right humerus and right hip fracture. R98 returned non weight bearing and was being medicated every 4 hours around the clock for pain management and was always observed in bed in her room. R98 had been followed by Hospice for End Stage Dementia since at least 7/09. During the survey, R98 was never observed in any meaningful activity.</p> <p>Review of R98's Significant Change Minimum Data Set (MDS), dated 10/9/09, was reviewed. It listed her preferred activities as "Cards/other games, Crafts/arts, Exercise/sports, Music, Reading/writing, Spiritual/religious activities, Trips/shopping, Watching TV, Talking or conversing."</p> <p>Review of R98's care plan identified a need for group activities and included approaches for group activities. Review of R98's activity logs revealed that she attended group activities for 2 days in October (10/11/09 and 10/16/09), 1 day in November (11/30/09) and 1 day in December (12/14/09) for a total of 4 days of group activities in three months.</p> <p>R98's Activity progress notes, dated 1/13/09 to 1/5/10, were reviewed: "1/13/09...attended some socials...daily 1:1 visits ..., 4/29/09...interest in some musicals events ...cont (continue) 1:1 visits ..., 7/30/09 ...son and daughter-in-law attended care conference ... does not attend organized</p>	F 248			

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F 248	Continued From page 15 activities ... will visit...daily with 1:1 ...for conversation & stimulation ..., 10/23/09...Care conference ...son attended with hospicedeclining and is remaining in bed at this time ...will visit c (with) 1:1 to comfort & socialize....1/5/10 readmitted ...will visit 1:1 to offer socialization and stimulation." Despite R98's care plan approaches for group activities, the stated goal was for 1:1 visits. Review of the "One-to-one participation sheet" revealed 1:1 visits documented once in September (9/23/09), once in October (10/21/09), 4 times in November (11/3/09, 11/15/09, 11/20/09 and 11/27/09) and once in December (12/29/09) This equated to 7 visits in 4 months. There was no other documented evidence of activities attended in 2009 for this resident. During an interview on 1/12/10 at 4:30 PM, E8 (Activity Director) agreed the Activity logs lacked evidence of R98's ongoing attendance on either group activities or 1:1 visits, stating the resident had declined since her fall on 1/1/10. E8 was unable to provide documentation to substantiate R98's attendance in any group activities prior to October 2009, such as those listed in the Activity Progress Notes. E8 also acknowledged that no changes had been made to R98's activity care plan despite the facility having been notified that R98 was not interested in "group activities" in July 2009.	F 248			
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	F253 1. Stained or dirty rugs in rooms 104, 106, 111, 112, 122, 127, 133, 135, 136, 137 and 138 will be extracted and cleaned. Loose chair handles were repaired on January 12, 2010. Brown dirt material on the toilet seat was removed on 1/8/2010.		3/21/10

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F 253	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observations during the survey and the environmental tour with the facility maintenance and housekeeping staff on 1/8/10, and staff interviews it was determined that the facility failed to provide maintenance and housekeeping services necessary to maintain an orderly and sanitary interior. Findings include: 1. Stained or dirty rugs were observed in resident rooms 104, 106, 111, 112, 122, 127, 133, 135, 136, 137, and 138. An interview with E4 (Maintenance and Operations Director) and E5 (Housekeeping director) confirmed this finding. 2. Loose chair handles were observed in the first floor dining room (7 of 20 chairs) on 1/4/10 and in the second floor dining room (3 of 20 chairs) on 1/8/10. 3. A toilet in the first floor spa was observed with encrusted brown dirt during the environmental tour on 1/8/10. An interview with E4 confirmed the finding.	F 253	2. Director of Housekeeping and/or designee will inspect carpeting in all resident room to determine whether or not they are soiled or discolored. Soiled carpets will be cleaned immediately. Spa room and resident rooms will be checked for brown dirt material and cleaned immediately. The Director of Maintenance checked all remaining dining room chair handles and repaired them on 1/12/2010 3. The Director of Housekeeping and/or designee will conduct random audits of resident room carpeting to determine if carpeting needs cleaning. Corrective action will be taken. Random audits will also be conducted on Spa Room and resident bathroom toilets. Corrective action will be taken. The Director of Maintenance will conduct random checks of chair handles		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279			

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NAME OF PROVIDER OR SUPPLIER

MILLCROFT

STREET ADDRESS, CITY, STATE, ZIP CODE
255 POSSUM PARK ROAD
NEWARK, DE 19711

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F 279	<p>Continued From page 17</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop care plans to meet residents' medical and nursing needs based on their comprehensive assessments for three out of 47 Stage II sampled residents (R155, R98, and R51). Findings include:</p> <p>1. R155 was admitted on 6/10/09 with diagnoses including stroke, diabetes and end stage renal disease. On 10/2/09, R155's physician ordered Aspirin and Plavix, anticoagulant medications, upon readmission to the facility after a hospitalization.</p> <p>The facility failed to develop a care plan for R155 related to being at risk for bleeding and bruising due to anticoagulation with Aspirin and Plavix use. On 1/7/10, findings were confirmed by E2 (DON).</p> <p>2. Review of R98's care plan, dated 3/8/07 and entitled, "Need for group activities in order to increase stimulation and socialization that will enhance overall quality of life" was reviewed. The approaches included, "Provide with monthly</p>	F 279	<p>and take corrective action.</p> <p>4. The results of the above audits will be reviewed by the QA Committee for the next 60 days as a means of assuring ongoing compliance.</p> <p>F 279</p> <ol style="list-style-type: none"> 1. Resident 51 is no longer in the facility, no corrective action can be taken. Resident 155 has not had an adverse reaction to the deficient practice. 2. All residents have the potential to be affected by this deficient practice. Care Plans will be reviewed and corrective action taken. 3. Nursing staff will receive In-service training on Assessment Protocol, Comprehensive Care Planning and appropriate documentation to meet individual needs. Training will be conducted by the Staff Development Coordinator and/or MDS Nurses. Random care plan audits of 	<p>3/27/10</p> <p>MDS (Mn) [Signature]</p>

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NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
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F 279	<p>Continued From page 18</p> <p>activity calendar, Review activities of interest..., Invite/Escort to group activities, Position next to other women with similar cognitive abilities to increase socialization opportunities, ... buddy up with other individuals during group activities, ...instructions should be kept simple, ...Encourage active participation in group activities." However, the stated goal was listed as "Resident will accept 1:1 visits in room."</p> <p>During an interview on 1/12/10 at 4:30 PM, E8 (Activity Director) agreed that the activity care plan did not have specific and measurable goals. The facility failed to have a goal that pertained to R98's stated problem, a need for group activities... and failed to have measurable objectives and timetables.</p> <p>3. The facility's "Urinary Tract Infection" clinical/infection control policy's preventative measures included "...On a regular basis (at least daily), clean the periurethral and perianal areas with mild soap and water and rinse well". Intervention included "If necessary, place resident on Intake and Output monitoring; increase fluid intake if allowable...Monitor resident's urine for odor, color, and amount of sediment". All interventions, symptoms etc are to be documented in the resident's record."</p> <p>R51 was admitted to the facility from the hospital on 7/31/09 for rehabilitation with an admitting diagnosis that included Urosepsis. R51's admission medications included the antibiotic "Vancomycin 250 mg 1 PO (orally) QID x 5 days".</p> <p>R51's admission Minimum Data Set (MDS) assessment, dated 8/11/09, indicated that this</p>	F 279	<p>10% of the daily census will be done by the DON and/or designee for the next 60 days. Corrective action will be taken to correct any problems found.</p> <p>4. The results of the audits will be reviewed by the QA Committee for the next 60 days to assure ongoing compliance.</p>		

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F 279	Continued From page 19 resident was frequently incontinent of bladder and bowel, and needed extensive assistance of one person with her activities of daily living (ADLs). R51 was assessed under MDS Section I #2 entitled "Infections" with "urinary tract infection in last 30 days". The MDS section P: "Special Treatments and Procedures" assessment included "intake and output" and "monitoring acute medical condition". The "RAP (Resident Assessment Protocol) Review Report" Summary Notes assessment date 8/7/09 identified that R51 was admitted "s/p hospitalization for urosepsis...recently treated for UTI (urinary tract infection)". R51's Comprehensive Care Plan initiated on 7/31/09 and completed on 8/3/09 did not include documentation in reference to the resident being at risk for UTI. The facility failed to ensure that R51's comprehensive care plan was revised and reflected the resident's risk for UTI/urosepsis and needs. An interview with E2 (DON) on 1/8/10 at 2:15 PM acknowledged this finding. On 8/16/09, R51 was re-admitted to the hospital with a primary diagnosis of "Severe sepsis of urinary tract origin".	F 279			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280	F280 1. R155, R80, R98, R225 received no harm from this cited deficient practice and remain in the facility.	3/21/10	

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F 280	<p>Continued From page 20</p> <p>interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the care plan was reviewed and revised for four out of 47 Stage II sampled residents (R155, R80, R98, and R225). Findings include:</p> <p>1. R155 had end stage renal disease and was receiving dialysis services. Review of the Renal Failure/ESRD (end stage renal disease) care plan last revised on 11/12/09 revealed that the care plan failed to include monitoring of vital signs and weights before and after dialysis, observation for signs and symptoms of infection, assessing of the dialysis site for bleeding and communication between dialysis and the facility.</p> <p>The facility failed to revise the care plan for R155 to include additional monitoring for a resident receiving dialysis services. On 1/7/10, findings were acknowledged by E2 (DON).</p> <p>2. R80 was admitted on 10/21/09 with diagnoses including congestive heart failure and pressure ulcers on the left foot and left buttocks. On</p>	F 280	<p>R155's care plan has been revised to include the appropriate monitoring approaches. R80, R98, and R225's care plan approaches have been revised to reflect their current needs and physician orders.</p> <p>2. All resident have the potential to be affected by this cited practice</p> <p>3. All license staff and the interdisciplinary team Will be provided in-service training on the care planning process and The need to revise care plans as needs changes. Care Plans will be reviewed on all residents to ensure that Approaches reflect the resident</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/12/2010
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NAME OF PROVIDER OR SUPPLIER

MILLCROFT

STREET ADDRESS, CITY, STATE, ZIP CODE

255 POSSUM PARK ROAD
NEWARK, DE 19711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
F 280	<p>Continued From page 21</p> <p>11/5/09, R80's physician wrote an order for, "Resident to wear heel protectors when in bed. Offload heels while in bed with heel protectors".</p> <p>Review of the alteration in skin integrity care plan last revised on 11/19/09 and the potential for alteration in skin care plan last revised on 10/21/09 revealed that both care plans failed to be revised to reflect the 11/5/09 physician's order for R80 to wear heel protectors when in bed and to offload heels while in bed. Both care plans also failed to note the offloading cushion that was on R80's bed to offload R80's heels.</p> <p>The facility failed to revise the alteration in skin integrity and potential for alteration in skin care plans to include heel protectors and offloading of R80's heels when in bed. On 1/8/10, findings were confirmed by E10 (LPN Unit Manager).</p> <p>3. R98's activity notes, dated 1/13/09 to 1/5/10, were reviewed. According to an activity note, dated 7/30/09, it was documented that R98 "...does not attend organized activities... will visit... daily with 1:1... for conversation & stimulation..." On 10/23/09 and 1/5/10, the activity notes revealed that R98 was declining and remaining in bed, and the plan was for 1:1 visits to continue. Review of R98's activity care plan, dated 3/8/07, revealed documentation that the care plan was reviewed on 7/30/09, 10/22/09 and 1/3/10, however, no revisions were made to this care plan to show that R98 did not attend group activities. The facility failed to revise R98's care plan to change the approaches from focusing on group activities to more individualized room activities and 1:1 visits as documented in the activity notes from 7/30/09 to 1/5/10.</p>	F 280	<p>current needs and physician orders.</p> <p>4. Random care plan audits will be completed monthly by the DON/designee on 10% of the facility population to ensure compliance. Findings will be reported to the to the QA Committee for the next 60 days to assure ongoing compliance.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2010
NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
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F 280	Continued From page 22 During an interview on 1/12/10 at 4:30 PM, E8 (Activity Director) acknowledged that when the care plan was reviewed, the needed revisions were not done. Cross refer to F309, Example #2. 4. Review of R225's clinical record revealed a physician's order dated 12/29/09, that stated, "Splint on right wrist for activity/transfer". The monthly POS (Physician Order Sheet) and the MAR (Medication Administration Record) indicated that the splint was to be worn at all times. Care plans entitled, "Self Care deficit" and "Orthopedic Aftercare" both initiated on 12/15/09, stated that the splint to the right wrist was to be worn at all times. The facility failed to revise the care plan to reflect physician orders for R225 to wear a splint on the right wrist for activity/transfer. Observation of R225 from 1/4/10 through 1/8/10 revealed that resident was not wearing the splint during activities, eating in room or dining room, or in physical therapy activities. On 1/8/10 at 5:00 PM, an interview with R225 revealed that she never used the splint until today at which time R225 was instructed to use the splint at all times.	F 280			
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to follow acceptable professional standards for two out of 47 Stage II sampled residents (R90, R155). For R90, the facility failed to follow professional standards in medication administration. For R155,	F 281	F 281 1. R155's Physician order sheet were corrected to reflect current orders and sent o pharmacy for amendment. R 90 is no longer in the facility no corrective action can be taken.		3/21/10

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F 281	<p>Continued From page 23</p> <p>the facility failed to follow professional standards related to the recap of physician orders (POS). Findings include:</p> <p>Cross refer F425</p> <p>1. Review of R155's 1/2010 POS revealed that the POS incorrectly stated Remeron for anorexia listed when the medication was ordered on 11/27/09 for 30 days only. Additionally, the 1/10 POS incorrectly listed R155's diet as dialysis renal carbohydrate controlled diet which was discontinued on 12/11/09 when R155's physician ordered a regular diet. Also, the 1/10 POS incorrectly listed supercereal for R155 which was discontinued on 10/27/09.</p> <p>The facility Medication Reconciliation policy and procedure, dated 11/21/07, was reviewed. The procedure included, "Medications are recapped on a monthly basis by the licensed nurse. All previous medications are reviewed for accuracy, changes in dosage, changes in medications, discontinuation of medications. All discontinued meds will be highlighted or some form of marking will be used to flag the discontinuation. Physician orders, previous medication sheet and all orders written in the last 30 days are reviewed for accuracy. All discontinued meds are checked for proper discontinuation and not forwarded to new medication order sheet and medication record."</p> <p>On 1/8/10, in an interview with E11 (Dietitian), E11 stated that R155 was currently on a regular diet in an effort to have her eat. Upon review of the 1/10 POS, E11 stated that the POS incorrectly listed R155's diet as dialysis renal diet, carb controlled which was discontinued on 12/11/09</p>	F 281	<p>E 13 was disciplined on 9/4/09 and did received training on how to properly identify residents before administering medications.</p> <p>2. All residents have the potential to be affected by this cited practice.</p> <p>3. All license staff will be provided in-servicing training on the recapitulation process of the physician order sheet and reconciliation of medications. Also will be provided in-service training on documentation of orders onto the care plan with approaches that reflects the resident's current Care needs.</p>	

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NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
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F 281	<p>Continued From page 24</p> <p>and changed to regular and had supercereal at breakfast which was discontinued on 10/27/09.</p> <p>On 1/8/09, in an interview with E10 (LPN Unit Manager), she stated that Remeron was discontinued in 12/09 and should have been discontinued on R155's 1/10 POS when the recap was done. E10 also stated that the diet and supercereal were incorrect on the 1/10 POS and should have been discontinued during the recap as well.</p> <p>The facility failed to meet professional standards of quality related to the recap of 1/10 POS for R155. E10 confirmed the findings and obtained clarification orders discontinuing Remeron and the incorrect diet and cereal orders. Additionally, E10 obtained clarification orders that reflected the current diet and current cereal orders. Cross refer, F333</p> <p>2. R90's nurse's note, dated 9/1/09 and timed 8:30 AM stated, "Medication nurse notified unit manager and ADON (Assistant Director of Nursing) that resident was given wrong medication..."</p> <p>Review of the facility's "Medication Administration Incident Report," dated 9/1/09, revealed that E13 (nurse) administered R90's roommate's medications to her erroneously. R90 received Aspirin 81 mg, Diovan HCT 80-12.5 mg (combination of an antihypertensive and diuretic), Lexapro 10 mg (antidepressant) and Metoprolol Succinate SR (sustained release) 25 mg (antihypertensive). Interview with E2 (DON) on 1/6/10 at 3:45 PM revealed that E13 failed to properly identify R90, which resulted in her receiving her roommate's medications.</p>	F 281	<p>4. An random audit will be completed monthly by the DON/Designee on 10% of the facility population to assure compliance, findings will be reported to the monthly QA Meeting for the next 60 days.</p>		

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NAME OF PROVIDER OR SUPPLIER

MILLCROFT

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255 POSSUM PARK ROAD

NEWARK, DE 19711

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F 281	Continued From page 25	F 281		
F 309 SS=D	<p>The facility failed to ensure that professional standards of practice and guidelines for medication management were followed. The National Guideline Clearinghouse (http://www.guideline.gov/summary/summary.aspx?doc_id=13483&mode=full&ss=15) lists the "Rights" of medication administration, which includes "Right Patient." The guideline indicates that two (2) forms of resident identification should be used prior to administering medications.</p> <p>483.25 QUALITY OF CARE</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well being of three (3) (R225, R227 and R122) out of 47 Stage II sampled residents in accordance with the comprehensive assessments and plan of care. The facility failed to ensure that R225 with a diagnosis of right fractured wrist had her right hand/arm splint applied in accordance with the current physician's order. The facility failed to ensure that R227 was assessed using a pain scale as required by the resident's care plan. The facility failed to ensure that the observed wound dressing treatment applied to R122</p>	F 309	<p>F 309</p> <p>1. R225, R227, R122 received no negative outcome from cited practices. R 225 hand splint is being applied as per Physician orders. R227 has been provided with an enlarged Pain scale that meets her visual needs to assist in determining her pain needs. R122 is currently receiving treatments as ordered by the physician. E11 will be provided re-education training on the individual resident plan of care.</p>	3/21/10

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F 309	<p>Continued From page 26</p> <p>reflected the current physician's order. Findings include:</p> <p>1. R225 was admitted to the facility on 12/15/09 with diagnoses including fracture of the right radius and fractured ribs. She was admitted to the facility with a hand splint. Review of social service assessment and history for resident R225 revealed she would be discharged to home after therapy.</p> <p>The admission MDS (Minimum Data Set) assessment, dated 12/22/09, identified that R225 had no short or long term memory problems, and that her cognitive skills for daily decision making were coded as "modified independence.</p> <p>Review of R225's clinical record revealed a physician's order dated 12/29/09, that stated, "Splint on right wrist for activity/transfer". The POS (Physician's Order Sheet) for the month of January, 2010 included an order for a splint, ordered on 12/16/09, that stated "splint on right hand/arm at all times. Keep clean and dry". The 1/10 MAR (Medication Administration Record) indicated that resident was supposed to wear the splint at all times. The care plan, dated 12/15/09, entitled, "Self Care deficit" stated, "Apply splint as ordered right wrist/hand at all times....". The care plan, dated 12/15/09, entitled, "Orthopedic Aftercare" stated, "Splint to right wrist and arm at all times...."</p> <p>Observation of R225 on 1/4/10 at 2:55 PM while in bed revealed she had no hand splint. Observation of R225 during lunch on 1/5/10 revealed she was eating in her room without a splint in her hand. Observation of R225 on 1/7/10 at 9:30 AM while she sat in her wheelchair in</p>	F 309	<p>E32 will be provided in-service education on pain assessment.</p> <p>E22 and E23 will be counseled, provided re-education and observations for proper wound treatment care.</p> <p>2. All residents who utilizes adaptive devices and who receive pain Medications have the potential to be affected by this cited practice.</p> <p>3. All license staff and direct care staff will be provided in-service Training on the utilization of individual resident care cards To ensure each resident care needs are met.</p> <p>All license staff will be provided in-service education on pain</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
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F 309	<p>Continued From page 27</p> <p>physical therapy revealed she had no hand splint. Observation of R225 on 1/7/10 at 10:50 AM while resident sat by the nurses station on first floor in her wheelchair revealed she had no hand splint. Observation of R225 on 1/7/10 at lunch in the dining area first floor revealed resident was not wearing a hand splint. Observation of R225 while she played bingo on 1/7/10 at 2:30 PM revealed she had no hand splint. Observation on 1/8/10 at 8:00 AM while resident was in bed eating breakfast revealed she was not wearing her splint. Observation on 1/8/10 at 9:00 AM prior to E11 (CNA) giving R225 a bed bath revealed that the resident was not wearing the splint in her hand. During an interview with E11 she acknowledged that the resident was not wearing a splint. Observations of R225 on 1/8/10 at 3:10 PM in her bed revealed she was wearing a splint on her right wrist. During an interview with R225 on 1/8/10 at 5:00 PM she stated that she never used the splint until today and was told to use the splint at all times. Findings were discussed and confirmed with the E2 (Director of Nursing) on 1/11/10. E2 stated that the order written on 12/29/09 was unclear and would need to be clarified. She acknowledged that the facility failed to clarify the order on 12/29/09 when it was first written.</p> <p>Facility failed to follow physicians order for the use of a hand splint for R225.</p> <p>2. During the med pass observation on 1/8/10 at 9 AM, E32 (nurse) administered Tylenol for complaints of a headache to R227. E32 failed to assess the "pain rating" on the "PRN (as needed) Analgesic Record/Pain Flow Sheet" when administering the pain medication. Additionally,</p>	F 309	<p>Assessment and wound treatment orders procedure.</p> <p>4. A Random audit will be completed monthly by the DON/Designee X 3month on residents utilizing adaptive devices to ensure compliance. A random audit will completed monthly by the DON/Designee on Residents receiving pain medication x3 months to assure compliance. A Random treatment observation will completed monthly DON/Designee X3 months and then quarterly to ensure compliance. Findings will be reported in the QA Committee for the next 60 days to assure ongoing compliance.</p>		

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F 309	<p>Continued From page 28</p> <p>E32 did not document the "pain relief rating" regarding the effectiveness of the medication.</p> <p>Review of R227's care plan, dated 12/18/09 and entitled, "Pain" revealed approaches that included, "...5. Evaluate effectiveness of analgesic through verbal signs of pain relief using pain scale 0-10." Review of R227's clinical record revealed that the numeric pain scale had only been used once when she was admitted to the facility during her initial pain assessment at which time, R227 had denied any complaints of pain.</p> <p>On 1/8/10, E32 was interviewed regarding the lack of documentation and this surveyor's observation of her lack of a pain assessment prior to administering the Tylenol to R227. When E32 was asked why she failed to use the numeric pain scale, she stated that she did not feel that R227 was capable of stating a "pain number due to dementia". Upon further questioning of how pain relief was assessed, E32 stated that she could bring in the prn analgesic record to show resident the "facial scale" on top of the record however, she did not believe the resident would be able to read it because the pictures were so small.</p> <p>During a follow-up interview on 1/8/10, E14 (Unit Manager) and E33 (Regional Nursing Director) agreed that the numeric scale was not being used and that the facial scale on the "PRN Analgesic Record/Pain Flow Sheet" was probably too small to read. They decided to enlarge the facial scale and included it on the MAR (Medication Administration Record) and revised R227's care plan to use that tool. E14 and E33 agreed that R227's pain assessments also needed to include documentation as to the location, intensity and effectiveness of the pain medication. E14 and</p>	F 309			

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F 309	<p>Continued From page 29</p> <p>E33 acknowledged that the facility had failed to follow the "Pain" care plan using the numeric pain scale and both agreed that it should have been revised to use the "facial scale" as that was more appropriate for this resident with dementia.</p> <p>3. R122's annual Minimum Data Set (MDS) assessment dated 11/30/09 revealed that this resident's "cognitive skills for daily decision-making were severely impaired-never/rarely made decisions". R122 was totally dependent on staff for all ADLs (activities of daily living).</p> <p>Review of R122's clinical record revealed a weekly "Wound Progress" note, dated 11/3/09, which documented a hospital acquired stage 3 pressure ulcer on the coccyx. R122's January 2010 TAR (Treatment Administration Record) revealed a physician's order, dated 12/31/09, to "Cleanse coccyx wound with NSS (normal saline solution). Apply thin coat of santyl with gauze foam pad q (every) day".</p> <p>On 1/8/10 @10:15 AM, the surveyor requested that E21 (treatment nurse) show her the resident's coccyx wound. It was observed that the wound dressing treatment previously applied to R122 on 1/7/10 only had a 4x4 thin gauze without the foam pad and did not reflect the current physician's orders for the wound treatment. Interview with E21 on 1/8/10 at 10:25 AM acknowledged this finding. In addition, E21 showed the surveyor that they had an adequate supply of the foam pads in the treatment cart. Additionally, review of the TAR also revealed that</p>	F 309			

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F 309	Continued From page 30 on 1/3/10 and 1/6/10 the treatment nurse failed to document completion of the ordered treatment. This finding was discussed with E14 (RN-Unit Manager) on 1/8/10 and E2 (DON) on 1/11/10. As a result of the facility's investigation of the incident dated 1/11/10, it was confirmed that E22 (LPN) performed an incorrect wound dressing change to R122 on 1/7/10. In addition, E23 (LPN) failed to document completion of the ordered treatment to R122's coccyx pressure ulcer area on 1/3/10. Interview with E14 on 1/11/10 also revealed that the wound dressing change was done on 1/6/10 by E14 but she also failed to document completion of the treatment. Review of the facility's documented result of the incident's investigation dated 1/11/10 revealed that E22 and E23 were disciplined and inserviced on wound assessments and implementation of wound care interventions as per physician's order and monitoring for effectiveness and documentation. In summary, the facility failed to ensure that the physician's order for R122's wound dressing treatment was accurately followed.	F 309			
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 312	F 312 1. R225 had no negative outcome from the cited practices and is currently receiving showers as per the shower schedule.		3/21/11

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NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
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F 312	<p>Continued From page 31</p> <p>determined that the facility failed to ensure that one (1) (R225) out of 47 sampled Stage II residents, who was unable to carry out activities of daily living (ADL's) received the necessary services to maintain personal hygiene. Findings include:</p> <p>R225 was admitted to the facility on 12/15/09 with diagnoses including fracture of right radius, fractured ribs, and UTI. The resident's MDS (Minimum Data Set) assessment, dated 12/22/09, indicated the resident's cognitive skills for daily decision making were modified independence (some difficulty in new situations only) and that she had no short or long term memory problems. This same MDS indicated that R225 required extensive assistance of one person for bathing and transfer.</p> <p>During an interview with R225 on 1/4/10, she stated "It would be nice to have a shower". She stated that she had not had a shower since she was admitted to the facility.</p> <p>ADL- CNA (Certified Nurse Aide) flow sheets from 12/16/2009 through 1/12/10 revealed that R225 was supposed to get a shower on Mondays and Thursdays during the second shift (3 PM - 11 PM). Review of these ADL flow sheets revealed that showers were not given on 12/17/09, 12/21/09, 12/24/09, 12/31/09, and 1/7/10. Refusals for a shower were noted on the ADL flow sheet on 12/28/09 and 1/4/10 on the 3 - 11 PM shift. There was no evidence that an alternate shower was offered.</p> <p>Review of nurses notes from 12/16/09 to 1/7/10 revealed that the only time a notation was written that R225 had refused a shower was on 1/4/10 on the 3-11 PM shift.</p> <p>During an interview on 1/8/10 with E30 (CNA), who worked the 7 AM - 3 PM shift, E30 confirmed</p>	F 312	<p>Refusals will be documented and with documented evidence that alternate shower has been offered. Care plan will be revised to reflect resident's shower needs.</p> <ol style="list-style-type: none"> 2. All residents have the potential to be affected by This cited practice. 3. All direct care staff and license staff will be provided In-service training on proper shower documentation And shower refusal procedures. 4. A random audit of the ADL flow-sheets will be completed by the DON/Designee weekly on 10% of the facility populations for one Month and then monthly x 3 months and reported to the QA Committee for the next 60 days as a means of assuring ongoing compliance. 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2010
NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
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F 312	Continued From page 32 that R225 had bed baths daily, not showers, during her shift. She stated that the resident had refused a bed bath this morning and stated that the shower was refused on 12/28/09. Staff interview with E31 (nurse) on 1/8/10 at 3:15 PM revealed that he was not aware why the resident had not received any showers since her stay at facility. He stated the resident had refused once during his shift (3-11 PM) because she was cold and in pain. He was not aware of why the resident had not had showers on the others days. In a second interview with R225 on 1/10/10, she again stated that "it would be nice to get shower" and that when showers were offered to her it was too late in the evening. The facility failed to provide showers for R225 for four weeks with no evidence that they were refused on five out of seven days that they were scheduled. Additionally, there was no indication that showers were offered at another time following the days that the resident refused.	F 312			
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315	F 315. 1. Resident R 51 is no longer in the facility. No corrective action can be taken. 2. All residents have the potential to be affected by the deficient practice. Nursing Administration will review residents with the potential to be affected and take corrective action.		3/6/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2010
NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
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F 315	<p>Continued From page 33</p> <p>Based on closed record review, review of the facility policy and procedures and interview, it was determined that the facility failed to ensure that one (R51) incontinent resident received the appropriate treatment and services to prevent UTI (urinary tract infection) and restore as much bladder function as possible. Findings include:</p> <p>The facility's Urinary Tract Infection policy was reviewed.</p> <p>1. R51 was admitted to the facility from the hospital on 7/31/09 with an admitting diagnosis of Urosepsis. Other diagnoses included c-diff (GI infection causing severe diarrhea), bilateral hydronephrosis, and acute renal failure/post surgical artery renal stent (kidney problems). R51's admission medications included "Vancomycin 250 mg 1 PO (orally) QID (once/day) x 5 days (discontinued on 8/5/09) and Lasix 40 mg. 1 PO daily.</p> <p>The facility's most current blood laboratory results dated 8/5/09 indicated that R51's BUN (blood urea nitrogen) was elevated at 39 mg/DL (normal range was 10-26 mg/dl) and creatinine value of 2.1 mg/dl (normal range was 0.5-1.5 mg/dl).</p> <p>According to the dietitian's Dietary Assessment Plan dated 8/3/09, R51's estimated fluid needs were 1500 cc.</p> <p>According to R51's admission Minimum Data Set (MDS) assessment dated 8/11/09, this resident's cognitive skills for daily decision-making were "independent-decisions consistent/reasonable". She was frequently incontinent of bladder and bowel and needed extensive assistance of one person with her activities of daily living (ADLs).</p>	F 315	<p>3. In-service training on resident assessments, comprehensive care planning and documentation to assure that each resident has the appropriate Plan of Care to meet individual needs. The training will be provided to the nursing staff by the Staff Development Coordinator and/or designee. Weekly random charts /care plans audit on 10% of daily census to assure of proper delivery of residents' comprehensive plan of care times 60 days by DON or designee.</p> <p>4. The results of the audits will be reviewed by the QA Committee for the next 60 days as a means of assuring on going compliance.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2010
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F 315	<p>Continued From page 34</p> <p>R51 was assessed for "urinary tract infection in last 30 days", and edema (fluid in lower extremities). The MDS section "Special Treatments and Procedures" identified included "intake and output" and "monitoring acute medical condition".</p> <p>According to the CNA 8/09 "Resident Meal Intake Record", R51's fluid intake for breakfast, lunch and dinner ranged from 360 cc to 900 cc of fluids/day. No other additional fluid intake needs were documented to ensure that this resident met the estimated requirement of 1500 cc of fluids daily.</p> <p>A nurse's note dated 8/6/09 and timed 2:00 PM stated, "Resident's children concerned about Resident thinks mother is lethargic and her infection previously at the hospital is coming back. Those were the symptoms she had- wants to talk with MD (physician) tomorrow".</p> <p>Review of R51's clinical record revealed that the facility did not establish a care plan to include R51's potential risk for Urosepsis/UTI, therefore, the facility failed to ensure that the care and services were provided for this resident. The facility lacked documented evidence that needed care and services/preventive efforts were defined, implemented, monitored and evaluated and that approaches were revised as appropriate. For example, but not limited to, the facility did not ensure that the resident's fluid intake was encouraged/monitored, resident's urine was monitored for odor, color and amount and documented in the resident's clinical record and proper perineal hygiene was provided as per facility policy.</p>	F 315			

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NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
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F 315	<p>Continued From page 35</p> <p>Interview with E2 (DON) on 1/8/10 @ 2:15 PM, she acknowledged that there was no care plan established to address the problem of R51's potential risk for urinary tract infection/urosepsis. There was no documented evidence of how care/preventive effort was provided to prevent recurrence.</p> <p>Subsequently, a nurse's note dated 8/16/09 and timed 0900 (9:00 AM) stated "Called to pts. (patient's) room where she was slow to respond....assess. difficult to arouse...unable to palpate BP (blood pressure) x3. Spoke with dtr. (daughter). Dtr. wishing her to go to ER. 911 called...911 EMS paramedics in. Resident still slow to respond. Unable to palpate radial pulse. MD notified."</p> <p>A nurses' note dated 8/16/09 and timed 1455 (2:55 PM) stated, "(name of physician) called...Resident is being admitted for Urosepsis."</p> <p>Review of the "Admission Hospital History and Physical" notes dated 8/16/09 stated, "Reason for ICU (Intensive Care Unit) admission: Severe sepsis... History of present illness.. brought in from nursing facility feeling unwell, fatigue, malaise, dry mucous membranes what appears to be UTI".</p> <p>Additionally, R51's Hospital Discharge Summary - (date unknown) stated, "Primary dx. (diagnosis) Severe sepsis of urinary tract origin". Plan: ...the patient is going to go home with daughter...to have skilled nursing visits as well as home physical therapy..."</p> <p>The facility failed to reduce the risk of R51's sustaining a recurrence of UTI/Urosepsis by</p>	F 315			

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F 315	Continued From page 36	F 315	F 329		3/12/10
F 329 SS=D	<p>failing to provide the appropriate treatment and services to prevent UTI and to restore as much normal bladder function as possible.</p> <p>483.25(l) UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that the facility failed to ensure that three (R226, R52 and R123) out of 47 Stage II sampled residents' drug regimen was free from unnecessary drugs due to inadequate monitoring. For R226, the facility failed to consistently monitor</p>	F 329	<p>1. R226, R52, R123 had no negative outcome from the cited practices. R226 will have a behavior Monitoring tool implemented to monitor the effectiveness of the Ativan as ordered. R52 has had LFTs lab work done with no abnormal findings. R123 will have a Behavior Monitoring tool implemented to monitor the effectiveness of the Ambien. A medication reduction review will be completed.</p> <p>2. All residents have the potential to be affected by this cited practice.</p> <p>3. All license staff will be provided in-service training on monitoring of residents receiving</p>		

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- F 329	<p>Continued From page 37</p> <p>the effectiveness of Ativan, an anti anxiety medication. For R123, the facility failed to consistently monitor the effectiveness of Ambien, a medication used for insomnia. For R52, the facility failed to do blood tests to monitor for side effects for several medications that she was taking. Findings include:</p> <p>1. R 226 was admitted to the facility on 12/15/09 with a fractured left leg. Review of the 12/09 Medication Administration Record (MAR) revealed that there was no behavior monitoring sheet for anxiety for R226. Review of the 1/10 MAR revealed that there was a behavior monitoring sheet which stated that R226 was receiving Ativan for insomnia rather than for anxiety as R226's physician ordered on 12/16/09. Additionally, the anxiety care plan, dated 12/16/09 included approaches, "Try alternative relaxation i.e. music devotional reading", "Administer meds per order - Ativan pm (as needed)" and "Monitor response to all interventions". However, there was no evidence of alternative approaches being implemented and documented on the behavior monitoring sheet or in the Nurses Notes (NN). The back of the 12/09 and 1/10 MARs and the NNs were reviewed when Ativan was administered to R226 to determine if the effectiveness of the medication was monitored. The effectiveness of the Ativan administered on 12/19/09, 12/23/09, 12/24/09, 12/30/09 and 1/6/10 failed to be monitored on the MARs or in the NNS. The facility failed to consistently monitor the effectiveness of Ativan as needed for anxiety for R226. On 1/11/10, the findings were confirmed with E2 (DON).</p> <p>2. R52 was admitted to the facility on 8/16/05 with multiple diagnoses including diabetes</p>	F 329	<p>psychoactive medications, and the use of unnecessary medications. The Unit Manager/Designee will follow up on all lab orders to assure that all labs ordered have been obtained. All residents receiving psychoactive medications will be reviewed quarterly by psychopharmacological medication review committee for reduction needs.</p> <p>4. A Random audit of lab orders will be completed monthly by The DON/Designee to assure sustained compliance. A Random audit will be completed monthly x 3 months and then quarterly on</p>		

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F 329	Continued From page 38 mellitus, hypertension and a history of a stroke. Review of R52's 1/10 physician's order sheet (POS) revealed that she had orders for Pravastatin Sodium a cholesterol lowering medication. The manufacturer of the medication recommends regular monitoring of liver function through blood testing every six months. The POS also listed orders for liver function tests (LFT's) to be done in June and January. There was no evidence in R52's clinical record that she had the blood drawn for the LFT in 6/09. An interview with E14 (nurse) on 1/7/10 confirmed that R52 did not have blood drawn for the LFT in 6/09 as per physician's orders. 3. R123 was admitted to the facility on 9/13/07. The annual Minimum Data Set (MDS) assessment, dated 11/10/09, revealed that she had diagnoses of anxiety and depression. Review of R123's 1/10 POS revealed an order for Ambien, 10mg daily at bedtime for insomnia, originally ordered on 6/8/09. The manufacturer's recommended geriatric dose for Ambien is 5mg for the short term treatment of insomnia. R123's clinical record lacked evidence of monitoring for the effectiveness of the Ambien in 12/09 and 1/10. In an interview with E14 on 1/12/10 she stated that there should have been monitoring sheets completed to record the effectiveness of the medication. Additionally, there was no documented evidence for the continued need of the higher dose of Ambien.	F 329	behavior monitoring to assure compliance. Findings will be reviewed by the DON and QA Committee for the next 60 days to assure ongoing compliance.		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of	F 333	F 333 1. Resident R 90 is no longer in the facility, no corrective action can be taken.		3/21/10

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F 333	<p>Continued From page 39 any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Cross refer F281, example #2 Based on clinical record review, interview and review of facility documents, it was determined that the facility failed to ensure that one (1) (R90) out of 47 Stage II sampled residents was free of any significant medication errors. Findings include:</p> <p>R90 was admitted to the facility on 7/11/09 for rehabilitation following hospitalization for a fractured hip. Additional diagnoses included hypertension and coronary artery disease. The admission Minimum Data Set (MDS) assessment, dated 7/17/09 identified this resident's cognitive skills for daily decision making as independent with no short or long term memory problems.</p> <p>A nurse's note, dated 9/1/09 and timed 8:30 AM, stated, "Medication nurse notified unit manager and ADON that resident was given wrong medication..." The same nurse's note stated that the Nurse Practitioner (NP) was notified and orders were received to monitor vital signs every two (2) hours until 11:00 PM and then every four (4) hours until 7:00 AM on 9/2/09.</p> <p>Review of the facility's "Medication Administration Incident Report," dated 9/1/09, revealed that E13 (nurse) administered R90's roommate's medications to her erroneously. R90 received her roommate's Aspirin 81 mg, Diovan HCT 80-12.5 mg (combination of a blood pressure lowering and water pill), Lexapro 10 mg (antidepressant)</p>	F 333	<p>2. All residents have the potential to be affected by the same deficient practice. The use of the Rights of Medication Administration and the use of two forms of ID will be put in place to assure the proper resident is receiving their medications. All residents will be checked for name band placement and those without will have name bands placed immediately.</p> <p>3. Employee E 13 was disciplined and received additional training on medication administration. Nursing staff will receive in-service training on the Prevention of Medication Errors. The training will be provided by the Staff Development Coordinator. Random medication observations of licensed nursing staff will be conducted by the DON and/or designee for the next 60 days. Corrective action will be taken.</p> <p>4. The results of the observations will be reviewed by the QA Committee for the next 60 days as a means of assuring ongoing compliance.</p>		

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F 333	<p>Continued From page 40</p> <p>and Metoprolol Succinate SR (sustained release) 25 mg (blood pressure lowering). In an interview with E2 (DON) on 1/11/10, E2 confirmed that the above medications were given to R90 on 9/1/09 in error.</p> <p>Interview with E2 revealed that E13 entered the room and called out the name of R90's roommate. However R90 responded yes. Observations during the survey revealed that not all residents wore identification bracelets. The facility did have resident pictures in the medication administration record.</p> <p>The clinical record revealed that R90's vital signs were monitored according to the NP's orders and remained within normal limits through 7:00 AM on 9/2/09. On 9/2/09 at 7:30 AM R90's blood pressure was 85/52 (low) which required the holding of two of her medications, Lasix (water pill) and Norvasc (blood pressure lowering). R90 also refused therapy services due to complaints of not feeling well. R90 was discharged to a private residence on 10/9/09.</p> <p>E13's written account of the event, dated 9/4/09, stated "...I could have double check (sic) 5R (5 Rights of Medication Administration) or call (sic) somebody to identify the resident for me. May be (sic) this way I could have able (sic) to stop the error..."</p> <p>The National Guideline Clearinghouse (http://www.guideline.gov/summary/summary.aspx?doc_id=13483&mode=full&ss=15) lists the "Rights" of medication administration, which includes "Right Patient." The guideline indicates that two (2) forms of resident identification should be used prior to administering medications. The</p>	F 333			

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F 333	Continued From page 41	F 333	F 366	3/1/10	
F 366 SS=D	<p>facility failed to ensure that R90 was properly identified as the right patient before medications were administered and failed to ensure that the resident was free of significant medication errors.</p> <p>483.35(d)(4) FOOD</p> <p>Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon observation and interview it was determined that the facility failed to provide substitutes of similar nutritive value for one (R87) out of 47 Stage II sampled residents who refused the food served. Findings include:</p> <p>During the dinner dining observation in the second floor dining room on 1/9/10, R87 still had his stew, untouched, on his plate. E15 (nurse), approached R87 and encouraged him to eat. R87 stated that he "didn't want it" and then said, "I can't eat this." E15 never asked why R87 could not eat or did not want his dinner and failed to offer him the alternate meal. Instead, E15 told R87 to try to eat his roll. Within minutes, R87 reached over and grabbed R37's Magic cup (nutritional supplement) and began eating it. E15 saw a surveyor watching, and stated that R37 had offered it to him. R87 ate the entire Magic cup.</p> <p>During an interview on 1/9/09 at 7:40 PM with E15, she acknowledged failing to offer R87 an alternate.</p>	F 366	<p>1. Resident R 87 has not had an adverse affect caused by the deficient practice. E15 will receive in-service training on proper dining procedures and the offering of substitutes. The Dietitian met with the resident to ask if he is being offered substitutes for food he does not want and will continue to meet periodically with the resident to assure his food needs are being met. Corrective action will be taken immediately if needed.</p> <p>2. All residents have the potential to be affected by the deficient practice. Meal observations will be conducted by nursing administration and/or facility's management personnel to assure the deficient practice does not occur. Immediate corrective action will be taken.</p> <p>3. Nursing staff will receive in-service training on Five Star's policy on meal substitution or alternatives. The training will be conducted by the Staff Development Coordinator and/or designee. Weekly random meal observations and the dining experience will be conducted by the DON and/or designee for the next 60 days. Corrective action will be taken.</p> <p>4. The results of the meal observations will be reviewed by the QA Committee for the</p>		
F 371 SS=E	<p>483.35(i) SANITARY CONDITIONS</p> <p>The facility must -</p>	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVAL
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2010
NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 371	<p>Continued From page 42</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, it was determined that the facility failed to maintain sanitary conditions for food storage, preparation, distribution and service. Findings include:</p> <p>1. Observations in the kitchenette in the first floor main dining room on 1/4/10 at the mid-day meal revealed that E26 (dietary staff) was using an unsanitized thermometer to test the food. E26 was observed using a paper towel to clean the thermometer between the testing of different food items which included pork, corn chowder, cucumber salad, cheese steaks, baked beans, and potato salad. During an interview with E26 at the time to determine if she had sanitizer to clean the thermometer she was observed reaching for a container called "Don 1469 Sanitizer wipes." E26 then used one of the sanitizing wipes, however, the wipe was dry and therefore failed to sanitize the thermometer. E26 confirmed the sanitizer wipes were dry. Interview with E7 (food service director) and E27 (Assistant Food Service Director) revealed the sanitizing wipes were supposed to be wet when the staff used them to sanitize the thermometer.</p>	F 371	<p>next 60 days as a means of assuring ongoing compliance.</p> <p>F 371</p> <p>1. Since E 26 was observed by the surveyor no corrective action was taken at that time however; E 26 will receive in-service training on the proper procedure for taking meal temperatures. No adverse affects were noted from the deficient practice. The employee who placed the large bag of rice and cereal boxes on the floor was instructed to remove the items from the floor and he did so. Employee E 29 was instructed on how to wear a hairnet and a new hairnet was properly placed.</p> <p>2. All residents have the potential to be affected by the deficient practice. The Director of food Service and/or designee will observe the tray line, food storage and use of hair nets to assure the deficient practice does not re-occur. Employee E 26 will be in-serviced of the proper procedure for monitoring food temperatures. E 29 will receive training on the proper use of hair nets.</p> <p>3. In-service training will be conducted for dietary staff on the proper procedure for checking food temperatures. Policy CL-DI-6048, Safe Food Temperatures will be reviewed</p>		3/21/11

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/12/2010
NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 43 2. Observations of the dry food storage area in the kitchen with E28 (Executive Chef) on 1/4/10 at 8:15 AM revealed a large bag of rice and an opened box containing bags of cereal on the floor. The label on the containers revealed that the food was delivered two days ago. 3. An observation in the kitchen on 1/4/10 at 9:30 AM revealed that the hair restraint failed to completely cover a foodhandler's hair while preparing food for lunch. Another staff by the steam table was observed with a bandana covering her front hair but her long hair in back was uncovered. Additionally, an observation in the kitchen on 1/11/10 at 5:30 PM revealed that E29 (dietary aide staff) failed to have a hair restraint. During an interview with E27 at the time, he stated that E29 should have been wearing a hair net.	F 371	during training. Training will also be provided on proper food storage and the proper use of hair nets. The training will be conducted by the Director of Food Service and/or designee. Random audits on food temperature taking will be conducted by the Dir. Of Food Service and/or designee for the next 60 days with corrective action taken if warranted. 4. The results of the audits will be reviewed by the QA Committee for the next 60 days as a means of assuring ongoing compliance.	
F 372 SS=B	483.35(i)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations of the garbage dumpster area and the second floor restorative dining room it was determined that the facility failed to properly store garbage and refuse as reflected by the accessibility of garbage to rodents, insects and birds. Findings include: 1. Observations on 1/4/10 at 8:50 AM of the dumpster area revealed the doors to one dumpster open and the lid of a second dumpster	F 372	F 372 1. The dumpster doors were closed after it was brought to staff's attention. Garbage can lids have been ordered and installed. No adverse affects were noted. 2. The Dir. of Maintenance and/or designee will monitor dumpster doors during the week and the Manager on Duty will monitor doors on the weekend to assure they are closed properly. The Director of Housekeeping and/or designee will monitor trash cans in dining room to assure the lids are in place. Corrective action will be taken. 3. Dietary, Housekeeping, Nursing and Maintenance employees will be in-serviced on	3/21/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2010
NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 372	Continued From page 44 full of bags of soiled diapers open. The opening was large enough to allow rodents and other pests access to the garbage. The Food Service Director confirmed these findings. 2. Two full garbage cans in the second floor restorative dining room were observed without lids on 1/4/10 at 9:23AM. Interview with E25 (Housekeeping staff) confirmed this finding. E25 stated the lids were ordered but were not in yet. On 1/11/10, the lids were observed on the trash cans but they were uncovered and full of garbage. This provided harborage for unwanted pests in the facility.	F 372	closing dumpster lids and doors and reporting broken or missing dining room garbage can lids. The Directors of Maintenance and Housekeeping and/or designee will conduct random audits for the next 60 days to assure compliance. Corrective action will be taken if warranted. 4. The results of the audits will be reviewed by the QA Committee for the next 60 days as a means of assuring ongoing compliance.		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425	F 425 1. Resident R 155 has not had an adverse affect caused by the deficient practice. The Physician Order Sheet for this resident was amended and sent to the pharmacy for revision. The Pharmacy was informed of the deficient practice and the consultant pharmacist will be instructed to more closely monitor physician orders during reconciliation. 2. All residents have the potential to be affected by the same deficient practice. Nursing Administration will review medical records to assure the same deficient practice has not occurred. Immediate corrective action will be taken.		3/27/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-033

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2010
NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 425	Continued From page 45 by: Based on record review and interview, it was determined that the facility failed to ensure that when pharmaceutical services received physician orders that the orders were processed accurately and reflected on the next physician order sheet (POS) for one (R155) out of 47 Stage II sampled residents. Findings include: R155's physician ordered Remeron for 30 days for anorexia on 11/27/09. The 12/09 Medication Administration Record (MAR) was reviewed and revealed that Remeron was discontinued after 30 days. The 1/10 POS incorrectly continued to have Remeron listed when it was generated from the pharmacy. Additionally, the 1/10 POS had an incorrect diet, dialysis renal carb controlled, that was discontinued on 12/11/09 and incorrectly had supercereal that was discontinued on 10/27/09. The facility failed to have the consulting pharmacy accurately review and generate the 1/10 POS for R155. On 1/8/10, during an interview with E12 (Consultant Pharmacist), she confirmed that the 1/10 POS had the diet incorrect and that the supercereal should not have been listed on the POS. Additionally, E12 confirmed that Pharmacy should not have had Remeron on the 1/10 POS it since was ordered for 30 days on 11/27/09.	F 425	3. Nursing staff will receive in-service training on Medication Reconciliation and the Re-cap process. The training will be provided by the Staff Development Coordinator and/or designee. Consultant Pharmacy will conduct in-service training for their Medical records personnel. Weekly random audits of the charts on 10% of the daily census will be done by the DON and/or designee. Monthly chart audits will be conducted by the Consultant Pharmacist. These audits will be conducted for the next 60 days and corrective action will be taken based on the findings. 4. The results of the audits will be reviewed by the QA Committee for the next 60 days as a means of assuring ongoing compliance		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in	F 441	F 441 1. Residents R 87 and 37 have not had an adverse affect from the deficient practice. No corrective action was taken for Employees E 15 or E 16 since the facility was not made aware of the deficient practice until survey exit. Employee E 16 will be disciplined and provided in-service training on Infection Control Practices during dining and meal service. E 9 will be disciplined and provided in-		3/21/10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2010
NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 441	<p>Continued From page 46</p> <p>the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of other facility documents, the facility failed to provide a safe, sanitary, and comfortable environment, to prevent the development and transmission of disease and infection. One staff was observed removing one resident's (R37's) soiled napkin from the second floor dining room floor and placing it on top of a table where another resident (R87) continued to eat. One staff failed to wash her hands after coughing into them yet continued to serve residents in the first floor dining room. Additionally, the facility failed to prevent contaminated air from the soiled linen room entering into the clean linen room and failed to handle soiled linens in such a way to remove the potential for aeration of contaminants in the air. Findings include:</p> <p>1. During the dinner dining observation on 1/9/10, E15 (nurse) used R37's blue cloth napkin to wipe up some spilled ice, leaving the napkin to cover the spill on the floor. A short time afterwards, E16 (CNA), picked up the soiled napkin used to mop the floor and placed it back on the table, where R87 continued to eat.</p> <p>During an interview on 1/9/09 at 7:40 PM, E15 acknowledged that the soiled napkin should never have been placed back on the table after it had been on the floor and agreed this presented an infection control issue.</p>	F 441	<p>service training on proper hand washing techniques. E 24 will be disciplined and provided training on the proper handling of soiled linen. The door between the dirty and clean laundry areas was replaced on 1/9/2010.</p> <p>2. All residents have the potential to be affected by the deficient practice. Nursing Administration will observe meals and laundry handling to assure the deficient practice does not occur and corrective action will be taken.</p> <p>3. In-service training will be provided to nursing staff utilizing Five Star's Infection control Policy including proper hand washing techniques and soiled linen handling. The training will be conducted by the Staff Development Coordinator and/or designee. Weekly random audits on infection control and dining will be conducted by the DON and/or designee to assure compliance and corrective action will be taken.</p> <p>4. The results of the audits will be reviewed by the QA Committee for the next 60 days as a means of assuring ongoing compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2010
NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE
F 441	<p>Continued From page 47</p> <p>2. On 1/4/10 at 11:53 AM, E9 (LPN) was observed coughing into her hands, and touching her clothing before passing bread to residents in the first floor main dining room. E9 failed to wash her hands prior to distributing the bread and placing butter on the bread. After serving the residents, E9 was then observed going into the kitchen to wash her hands.</p> <p>The facility procedure entitled "Handwashing" stated "handwashing is performed after coughing, sneezing, or blowing nose", and "before eating or handling food".</p> <p>3. On 1/8/2010 at 2:35 PM, the door between the laundry clean linen drying area and the soiled linen area was observed with a crack of about one inch around the door drawing contaminated air from the soiled linen room into the clean linen room. Staff interview (E4) confirmed this finding.</p> <p>4. On 1/6/2010 at 10:00 AM, E24 (Certified Nurse Aide) was observed pulling the bags of soiled linen from an overflowing linen cart and throwing them into a larger soiled linen hamper in the laundry room area. Soiled linen was observed falling out of one bag (which came open) and some linen falling inside the container and on the floor. This caused aeration of contaminants in the air. Guidance from the Center for Disease Control recommends that soiled linen be handled in such a way to remove potential for aeration of contaminants in the air.</p> <p>Facility procedure entitled "Soiled Linen Handling" revealed that soiled bed linen should be removed in a manner to prevent excessive airing of linen.</p>	F 441			
F 463	483.70(f) RESIDENT CALL SYSTEM	F 463			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2010
NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 463 SS=D	<p>Continued From page 48</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations on 1/5/10 during stage I, and staff interview, it was determined that the facility failed to maintain the nurse call alarm system for R44's and R233's bathroom. Findings include:</p> <p>Observations of the bathroom for R44 and R233 call bell system on 1/15/10 revealed that the alarm system was malfunctioning (did not light up or sound at the electronic panel). Staff interview with E20 (LPN) on 1/5/10 revealed the call system was not working for that room. Interview with maintenance staff on 1/6/10 at 9:00 AM revealed that the call system had to be reset at the computer. After they reset the computer, the call bell began functioning.</p> <p>On 1/12/10 at 8:02 AM, surveyor overheard a nursing staff stating to the administrator that the resident call bell in room 219 was not working and had to be repaired. Surveyor noticed the administrator paging maintenance and stating the computer needed to be reset.</p> <p>Record review of maintenance logs revealed that a few calls bells are tested at random on a monthly basis by security staff. The facility failed to ensure that testing of the call bells was performed frequently enough to ensure all call bells were functional.</p>	F 463	<p>F 463</p> <ol style="list-style-type: none"> 1. The nurse call system for residents R 44 and 233 was checked on 1/5/2010 and was repaired. 2. All residents have the potential for the same deficient practice. The call bell system will be monitored daily for the next 60 days and corrective action taken. 3. The Arial Call Bell System performs self checks on all devices every 15 seconds and any problem areas are recorded on the main computer terminal. The Director of Maintenance, Administrator and/or designee will check the system daily. The 2nd floor Charge nurse and weekend MODs will be trained on how to read the computer and reset the system. All problem areas will be immediately reported to the Director of Maintenance or Administrator for corrective action. The Director of Maintenance and/or designee will conduct checks of 20% of all call bell boxes for the next 60 days. Immediate corrective action will be taken. 4. The results of the audits will be reviewed by the QA Committee for the next 60 days as a means of assuring ongoing compliance. 		3/6/10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/12/2010
NAME OF PROVIDER OR SUPPLIER MILLCROFT			STREET ADDRESS, CITY, STATE, ZIP CODE 255 POSSUM PARK ROAD NEWARK, DE 19711		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

LTC Residents Protection

STATE SURVEY REPORT

FEB 15 2010

Director's Office

NAME OF FACILITY: Millcroft

DATE SURVEY COMPLETED: January 12, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual and complaint survey was conducted at this facility from January 4, 2010 through January 12, 2010. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 93. The survey sample included forty (40) Census Sample residents and thirty (30) Admission Sample residents in Stage 1. The Stage 2 sample totaled forty-seven (47) residents. Additionally, there were two sub-sampled residents (SSR1 and SSR2) who were not part of the Stage 2 sample.</p>	<p>This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Millcroft agrees with the allegations and citations listed on the statement of deficiencies. Millcroft maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall serve as Millcroft's written credible allegation of compliance as of the last POC completion date.</p> <p>By submitting this plan of correction, Millcroft does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Millcroft reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.</p> <p><i>Completion dates will be the same as listed on CMS 2567-L.</i></p>
3201	Skilled and Intermediate Care Nursing Facilities	
3201.6.0	Services To Residents	
3201.6.1	General Services	
3201.6.1.1	The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet	

Provider's Signature [Signature]

Title Administrator

Date 3/15/2010



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 2 of 9

NAME OF FACILITY: Millcroft

DATE SURVEY COMPLETED: January 12, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	their medical, nursing, nutritional, and psychosocial needs. Cross-refer to CMS 2567-L, survey date completed 1/12/10, F253, F281, F309, F312, F315, F329, F333, F425, and F441.	<i>Cross Reference CMS 2567-L for F253, F281, 309, 312, 315, 329, 333, 425 and 441. This is our Plan of Correction.</i>
3201.6.5	Nursing Administration	
3201.6.5.6	A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings. Cross-refer to CMS 2567-L, survey date completed 1/12/10, F279.	<i>Cross Reference CMS 2567-L for F279. This is our Plan of Correction.</i>
3201.6.5.7	The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A	<i>Cross Reference CMS 2567-L for F280. This is our Plan of Correction.</i>



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STATE SURVEY REPORT

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NAME OF FACILITY: Millcroft

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3201.6.6	complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.	
	Cross-refer to CMS 2567-L, survey date completed 1/12/10, F280.	
3201.6.6.1	Activities The nursing facility's activities program shall provide diversified individual activity plans and group activities for each resident based on the comprehensive assessment as well as an activity assessment conducted by the activity director. The activities offered shall reflect the needs, interests, abilities, preferences, limitations and age of each resident.	<i>Cross Reference CMS-2567-L for F248. This is our Plan of Correction.</i>
3201.6.8	Food Service	
3201.6.8.1	Meals	
3201.6.8.1.3	When residents refuse a meal served, substitutes of similar nutritive value shall be offered.	<i>Cross Reference CMS-2567-L for F366. This is our plan of Correction.</i>



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3201.7.0	Cross-refer to CMS 2567-L, survey date completed 1/12/10, F366. Plant, equipment and Physical Environment	<i>Cross reference CMS 2567-L for F 463. This is our plan of correction.</i>
3201.7.3	Facility Systems Requirements	
3201.7.3.4	The facility shall be equipped with a resident call system which meets the current standards of the Guidelines for Design and Construction of Health Care Facilities. An intermediate care facility serving only developmentally disabled residents shall be exempt from this regulation.	
3201.7.5	Cross-refer to CMS 2567-L, survey date completed 1/12/10, F463. Kitchen and Food Storage Areas	<i>Cross reference CMS 2567-L for F.371. This is our Plan of Correction.</i>
3201.7.5.1	Facilities shall comply with the Delaware Food Code. This requirement is not met as evidenced by: Based on the dietary observation during the survey, it was determined that the facility failed to comply with sections: 2-402.11, 3-302.11, 3-305.11, 5-501.110, 5-501.113 (A) of the State of	



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	<p>Delaware Food Code. Findings include:</p> <p>2-402.11 Effectiveness.</p> <p>(A) Except as provided in ¶ (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to CMS 2567-L, survey completed 1/12/10, F371, example 3.</p> <p>3-304.11 Food Contact with Equipment and Utensils.*</p> <p>Food shall only contact surfaces of equipment and utensils that are cleaned and specified under Part 4-6 of this Code and sanitized as specified under part 4-7 of this Code.</p> <p>This requirement is not met as evidenced by:</p>	



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Cross refer to CMS 2567-L, survey date completed 1/12/10, F371, example 1.

3-305.11 Food Storage.

(A) Except as specified in 111 (B) and (C) of this section, food shall be protected from contamination by storing the food:

(3) At least 15 cm (6 inches) above the floor.

This requirement is not met as evidenced by:

Cross refer to CMS 2567-L, survey date completed 1/12/10, F371, example 2.

5.501.110 Storing Refuse, Recyclables, and Returnables.

Refuse, recyclables, and returnables shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents.

This requirement is not met as evidenced by:

Cross refer to CMS 2567-L, survey date completed 1/12/10, F372, example (a).

Cross reference CMS 2567-L for F371. This is our Plan of Correction.

Cross reference CMS 2567-L for F372. This is our Plan of Correction.



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5-501.113 Covering Receptacles.

Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered:

(A) Inside the food establishment if the receptacles and units:

- (1) Contain food residue and are not in continuous use; or
- (2) After they are filled.

This requirement is not met as evidenced by:

Cross refer to CMS 2567-L, survey date completed 1/12/10, F372, example (b).

Patient's rights.

It is the intent of the General Assembly, and the purpose of this section, to promote the interests and well-being of the patients and residents in sanatoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interests of the

16 Del. C.,
Chapter 11,
Subtitle II, §
1121

*Cross reference CMS 2567-L for
F 241. This is our Plan of Correction*



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patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which shall include but not be limited to the following:

(1) Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.

Cross-reference to CMS 2567-L, survey date completed 1/12/10, F241.

16 Del. C.,
Chapter 11,
Subtitle III, §
1132

Reporting requirements.

(a) Any employee of a facility or anyone who provides services to a patient or resident of a facility on a regular or intermittent basis who has reasonable cause to believe that a patient or resident in a facility has been abused, mistreated, neglected or financially exploited shall immediately report such abuse, mistreatment, neglect or financial exploitation to the Department by oral communication. A written report shall be filed by the employee or

*Cross reference CMS 2567-L for
F241. This is one plan of correction.*



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service provider within 48 hours after the employee or service provider first gains knowledge of the abuse, mistreatment, neglect or financial exploitation.

Cross-refer to CMS 2567-L, survey date completed 1/12/10, F225.